

University of Groningen

Theoretical resources for a globalised bioethics

Verkerk, Marian A.; Lindemann, Hilde

Published in:
Journal of Medical Ethics

DOI:
[10.1136/jme.2010.036830](https://doi.org/10.1136/jme.2010.036830)

IMPORTANT NOTE: You are advised to consult the publisher's version (publisher's PDF) if you wish to cite from it. Please check the document version below.

Document Version
Publisher's PDF, also known as Version of record

Publication date:
2011

[Link to publication in University of Groningen/UMCG research database](#)

Citation for published version (APA):
Verkerk, M. A., & Lindemann, H. (2011). Theoretical resources for a globalised bioethics. *Journal of Medical Ethics*, 37(2), 92-96. <https://doi.org/10.1136/jme.2010.036830>

Copyright

Other than for strictly personal use, it is not permitted to download or to forward/distribute the text or part of it without the consent of the author(s) and/or copyright holder(s), unless the work is under an open content license (like Creative Commons).

The publication may also be distributed here under the terms of Article 25fa of the Dutch Copyright Act, indicated by the "Taverne" license. More information can be found on the University of Groningen website: <https://www.rug.nl/library/open-access/self-archiving-pure/taverne-amendment>.

Take-down policy

If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.

Downloaded from the University of Groningen/UMCG research database (Pure): <http://www.rug.nl/research/portal>. For technical reasons the number of authors shown on this cover page is limited to 10 maximum.



Theoretical resources for a globalised bioethics

Marian A Verkerk,¹ Hilde Lindemann²

¹University Medical Center Groningen, University of Groningen, Groningen, The Netherlands

²Department of Philosophy, Michigan State University, East Lansing, Michigan, USA

Correspondence to

Dr Marian A Verkerk, University Medical Center Groningen, University of Groningen, Postbus 30001, 9700 RB Groningen, The Netherlands; m.a.verkerk@med.umcg.nl

Received 21 March 2010

Revised 27 August 2010

Accepted 17 September 2010

Published Online First

25 November 2010

ABSTRACT

In an age of global capitalism, pandemics, far-flung biobanks, multinational drug trials and telemedicine it is impossible for bioethicists to ignore the global dimensions of their field. However, if they are to do good work on the issues that globalisation requires of them, they need theoretical resources that are up to the task. This paper identifies four distinct understandings of 'globalised' in the bioethics literature: (1) a focus on global issues; (2) an attempt to develop a universal ethical theory that can transcend cultural differences; (3) an awareness of how bioethics itself has expanded, with new centres and journals emerging in nearly every corner of the globe; (4) a concern to avoid cultural imperialism in encounters with other societies. Each of these approaches to globalisation has some merit, as will be shown. The difficulty with them is that the standard theoretical tools on which they rely are not designed for cross-cultural ethical reflection. As a result, they leave important considerations hidden. A set of theoretical resources is proposed to deal with the moral puzzles of globalisation. Abandoning idealised moral theory, a normative framework is developed that is sensitive enough to account for differences without losing the broader context in which ethical issues arise. An empirically nourished, self-reflexive, socially inquisitive, politically critical and inclusive ethics allows bioethicists the flexibility they need to pick up on the morally relevant particulars of this situation here without losing sight of the broader cultural contexts in which it all takes place.

In an age of global capitalism, pandemics, far-flung biobanks, multinational drug trials, telemedicine, and international academic conferences, it is impossible for bioethicists to ignore the global dimensions of their field.^{1–3} Consider, for example, the ethical issues that arise in large-scale clinical trials held in multiple sites around the globe. These are typically sponsored by pharmaceutical companies with proprietary interests in the results, so they do not often report negative findings: in a recent review of 5000 studies identified as potentially relevant, Hopewell and colleagues⁴ determined that only five included all findings. Because the large number of unpublished studies are likely to skew the published data, they present both an epistemological and an ethical problem, and this might be exacerbated if negative results are more pronounced in one part of the world due to some factor for which there was no control. How should bioethicists think about this when, as Rebecca Kukla points out in her talk, the death of the author in contemporary biomedical research, given at the Temple University School of Medicine in 2009. The trials are so large that there is often no

principal investigator and indeed there may be no one person who understands and can explain everything that is going on in the trial? More specifically, what theoretical resources do bioethicists need if they are to tackle problems like these effectively?

In their enormously influential 'Principles of biomedical ethics', Tom Beauchamp and James F. Childress⁵ promoted the use of four middle-level principles—autonomy, beneficence, non-maleficence and justice—that can be derived from almost any conception of the good and the right and are said to be applicable anywhere. According to the medical sociologist Raymond De Vries and colleagues,⁶ principlism, as it is now called, remains by far the most popular way to do bioethics in the USA. In other Anglophone countries, utilitarianism, Kantian ethics and human rights theories—all with claims to universality—are the preferred modes.

It might seem as if these approaches are just what is needed for work at the global level. Surely here if anywhere bioethicists need moral theory that transcends cultural differences and offers universalisable guidelines for action. In this paper, however, we—a Dutch bioethicist and her American colleague—argue that this sort of theory is not up to the task of reflective, critical and evaluative analysis required in global contexts. To demonstrate this, we identify four distinct understandings of globalisation in the bioethics literature, examine the theoretical assumptions that undergird them, and show how each misses problems that are in serious need of bioethical attention.

We then argue that a better way to deal with the moral puzzles of globalisation is to develop a normative framework that is sensitive enough to register morally relevant differences among us instead of vainly attempting to transcend them. At the same time, it must keep a sharp eye on the political and social networks in which people are differently enmeshed. An empirically nourished, self-reflexive, socially inquisitive, politically critical and inclusive ethics, we submit, allows bioethicists the flexibility they need to pick up on the particulars of this situation here without losing sight of the broader cultural contexts in which it all takes place.

FOUR MEANINGS OF GLOBALISATION

In the bioethics literature, 'globalisation' is understood in at least these four ways:

1. A focus on global issues, such as unjust distributions of health care between the global north and south. Norman Daniels,⁷ for example, has argued that for decades, bioethics has been fixated on the dyadic doctor–patient relationship and the ethical significance of exotic medical technologies, all the while ignoring the broader context in which these issues arise.

His remedy is to focus on questions of equity, such as intergenerational equity in the context of societal ageing, health disparities among different social groups and unequal distributions of health care on an international scale.

2. An attempt to develop a universal ethical theory that can transcend cultural differences. Peter Singer and colleagues,⁸ for instance, offer a rationale for a global health ethics grounded in utilitarianism—a theory whose rules of duty aspire, as Henry Sidgwick⁹ aptly put it, to ‘precise definition in universal form’. Similarly, Thomas Pogge¹⁰ lays out a research programme for a globalised bioethics based on a normative framework of universal human rights.
3. An awareness of how bioethics itself has expanded across the globe. Sirkku Hellsten¹¹ notes that the interactions among the diverse scholarly communities in the world amounts to a globalisation of the field of bioethics in general. Mark Aulisio¹² likewise comments that ‘bioethics has become a citizen of the global village’, with new centres, departments, organisations and journals emerging in nearly every corner of the globe. In addition to the International Association of Bioethics and the International Network on Feminist Approaches to Bioethics, there are now numerous international, national, regional and local bioethics centres connected to each other by research partnerships and other forms of collaboration. Bioethics is so well established globally that it has found its way to WHO and the United Nations.
4. A concern to avoid cultural imperialism in encounters with other societies. Feminist bioethicists in North America, the UK and Australia in particular have called for a greater sensitivity to differences among cultures. According to Alison Jaggar,¹³ as globalisation increasingly draws non-western cultures into its net, there is a danger that these cultures will be exploited by powerful western interests. Françoise Baylis, Susan Sherwin, Heather Widdows, Donna Dickinson, and others have argued that the imposition of western-style abstract, individualistic, universalist ethical norms on people to whom these concepts are foreign is a form of oppression that bioethicists should resist.^{14 15}

Each of these approaches to globalisation has some merit, as we shall show, but because the theoretical tools they employ are not, by and large, designed for cross-cultural ethical reflection, they leave important considerations hidden.

We begin with the focus on global issues. Daniels⁷ is to be commended for turning his attention to problems of globalisation, but because he has adopted a Rawlsian theoretical framework, he concentrates on issues of global distributive justice. While these are important and indeed pressing, a single-minded focus on the distribution of goods and services, as Iris Marion Young¹⁶ has argued, misses the powerful social forces that produce inequities of distribution in the first place. Moreover, other staples of bioethical concern are also affected by globalisation. For instance, globalising technologies such as the internet and email make telecare possible, and this has a profound effect on the doctor–patient relationship.¹⁷ Similarly, the globalised nature of research on the human genome raises questions about cultural identities, exploitative investigative practices, and other ethical issues that do not fit under the rubric of distributive justice. Research ethics, as we indicated earlier, takes on many new dimensions in a globalised academic economy.

The attempt to develop a universal ethical theory can be applauded for the impulse that motivates it, namely, to do the work of reflection and justification in as unbiased a manner as

possible. Here again, however, we focus on what it leaves out. For one thing, the language of principles, rights, utilities and duties sits uneasily in the company of intimate human relationships such as love, family and friendship.¹⁸ It fares little better in the domain of social group relations, especially when these are abusive power relations. Moreover, moral theories that universalise by flattening out differences among moral actors are likely to overlook important players and so deprive them of their due.

To see that problem more clearly, let us return to our telecare example. Telecare can be a boon to the frail elderly because it allows them to remain at home, where they can enjoy greater independence and the comfort of familiar surroundings. On a principlist approach within a universal ethical framework it can therefore be ethically justified on the grounds of respect for patient autonomy. However, such a framework idealises ‘the’ moral actor—here, the elderly person—as dependent on no one but himself and unencumbered by ties to others. This renders invisible the real-time, non-ideal family caregivers whose work is generally required to sustain the elderly person’s autonomy and keep him independent. (That the universal framework is totally silent about the gender identity of these invisible caregivers goes without saying.)

On a principlist approach, to be sure, one could weigh the principle of autonomy against the principle of justice and decide that telecare courts the danger of exploiting the home caregivers. But because, like other standard moral approaches, principlism is heavily individualistic, it does not make it easy for the moral deliberator to see the patient as nested in a web of intimate relationships that sustain her care. It is not that principlism makes it impossible to see the moral situation in that way—it is just that it does not make it easy. The philosopher Cheshire Calhoun¹⁹ calls theoretical biases of this kind ‘ideologies of the moral life’, and bids us to ‘ask what ideologies of the moral life are likely to result from the repeated inclusion or exclusion of particular topics in moral theorising’. What is needed here, instead of the assumption of an idealised moral agent whose choices are guided by four universalisable principles, is an ethical analysis that tracks actual assignments of responsibility and incorporates the perspectives of all parties to a given moral situation.

That bioethics itself has expanded across the globe has been explained by appealing to its unbounded nature. As Aulisio¹² observes, ‘Many of its core issues cut across traditional boundaries, be they disciplinary, cultural, religious, national or international.’ The perspectives of non-western bioethicists are generally welcomed as valuable not only because they enrich the standard bioethical debates, but also because they draw attention to the multicultural aspects of US, British, Canadian and European societies themselves. Here too, however, something is left out. The enrichment in question typically comes down to an appreciation of how ill-suited an autonomy-based or consequentialist, individualist ethics is to reflecting on situations involving people with deeply held communal values. This observation is often accompanied by reminders that western notions of the self are not universally shared.²⁰ We think a different kind of reflection is needed. In the international research partnerships and cross-cultural collaborations that now more than ever characterise bioethics, we call for bioethicists to be self-reflective, paying careful attention to their own social location and its attendant assumptions and perquisites. This kind of critical reflection might prompt the thought that bioethicists too are raced and classed, dependent on others for long stretches of their lives, and blinkered by the sight lines that

attend all human points of view. Such reflection in turn might make it easier to resist the temptation to picture the bioethicist as somehow hovering above the fray, rendering moral judgments from an unspecified epistemic position external to that of the actors in the instant case.

The concern to avoid cultural imperialism is particularly important, given the sorry tradition of colonialism, whose effects continue to cause suffering not only in the global south but among indigenous and formerly enslaved people in the north as well.¹³ In bioethics, the non-idealised feminist theory, critical race theory and colonial studies that have provided the basis for this approach to globalisation have largely been promoted by feminists. Their theoretical resources capture more of the differences among people and the social networks that connect them than do the impartialist, individualistic, universal theories that inform the other three approaches. Even here, however, something is left out. Although feminists have subjected their own theories to rigorous criticism, they have not always been careful to locate themselves within the moral situations that are the object of their reflections.

Moreover, when they contest a dominant group's view of who must do what, they have not always been careful to explain what kind of authority their alternative view of the matter possesses. For example, in an article on cross-cultural determinations of child abuse and neglect, Françoise Baylis and Jocelyn Downie²¹ discuss a traditional Laotian healing technique for the Mien folk illness of *Ghusia mun toe*, which involves a mother's burning a reed dipped in pork fat and passing it across her baby's abdomen. They argue that this tradition must be respected, but not if it raises blisters: when a cultural practice subjects a child to harm, 'the dominant community's beliefs and values should prevail'. Nowhere in the article, however, do they explain why the dominant community's medically imposed injuries are morally acceptable, while the injuries of other cultures are ruled out of court. Nor, for that matter, do they explain whose court it is or where it gets its legitimacy.

A NATURALISED, PARTICULARISTIC, GLOBAL BIOETHICS

We accept Margaret Walker's²² argument for an ethics that is empirically nourished but also acutely aware that ethical theory is the practice of particular people in particular times, places, cultures and professional environments. The bioethics we favour is naturalised, but it does not privilege knowledge produced by institutionally organised hard and soft science. Many kinds of knowledge, some of it local or narrative or experiential, and all of it socially situated, enter into its deliberations. A naturalised bioethics, then, is wary of idealisations that bypass social realities ('all moral agents have a rational life plan'). It is equally suspicious of purely 'reflective' approaches to ethics that are apt to reflect only some—usually the most socially privileged—moral points of view.²³

A particularistic ethics notices that the social fabric is permeated with morality; moral understandings are always socially embedded. For that reason, a particularistic global bioethics pays close attention to the particular social setting in which a puzzling moral issue has arisen, but because it situates people in relational networks of shared understandings it also pays attention to the broader context. When enough understandings are in fact shared between you and us, we can speak of a moral community; when you and we cannot make enough sense of each other even to disagree, there is no community at all. Even then we might have responsibilities to you—or your descendants—depending on how vulnerable you are to what we

do. Because of our global connections, there is an ongoing intertwinement of responsibilities.

A naturalised, particularistic global bioethics sees morality as a set of social practices. On this view, morality is not a branch of knowledge (although all sorts of knowledge are needed to participate in it). It is, rather, something we do together. It consists in taking, sharing, deflecting, or assuming responsibility for different things—and these practices of responsibility both allow and require people to see themselves and their relationships as defined by particular moral values. The bioethicist's role (we follow Walker²² here) is to analyse and reflect upon this practice in at least three ways:

1. Reflective analysis sets itself the task of examining the socially shared moral understandings that sustain actual practices of responsibility and ascertaining how these understandings work. This requires a familiarity with social positions other than the ethicist's own, because from some of those positions, certain understandings might make a different kind of sense, or no sense at all. The bioethicist must therefore acquire all the information she can get about the various forms that morality takes in different neighbourhoods of a particular moral community. If she wants to work cross-culturally, as we two do on a fairly regular basis, she needs to be continually aware that the things she takes for granted might not be at all the same in a culture that is foreign to her.
2. Critical reflection asks whether the socially shared moral understandings under examination really are shared by all those who enact them, and whether they are equally intelligible to all. What allows those understandings to operate properly? Do certain unsavoury aspects have to be concealed? Do some people have to be manipulated or coerced? This kind of reflection aims to determine whether the moral arrangements can account for themselves morally, in their own terms, which means that the bioethicist must have knowledge of not only the actual practices of responsibility but also its participants' conceptions of them. While reflective analysis is descriptive, critical reflection is normative, in that it holds moral relations and understandings to moral standards: if purportedly moral interactions are in fact based on manipulation or brute force, they are not moral ones, even though they appear to be.
3. Finally, normative reflection is the attempt to determine whether a particular way of life is good for people in the particular historical, cultural and material set of circumstance in which they live. It rejects idealisations that do not capture what any particular people are doing at a given place and time. It also denies the existence of any superior perspective to which we could appeal to assess critically the culture we inhabit. It insists that there are moral facts of the matter, although it is deeply sceptical of attempts to locate them outside any actual moral communities. It takes advantage of the space of moral reflection in which the question about morality's authority is raised. Just as that space contains moral vocabulary for asking that question, so too does it contain the moral ideas and standards that must be involved in answering it. The answer will be comparative, a matter of trying to find out whether some ways of living really are better than others.

HOW THE BIOETHICIST MIGHT PROCEED

On this naturalised and particularistic view of morality, how might the bioethicist think about, for example, the role of informed consent in globalised health? Because the model is

collaborative, she does not sit alone in her room and conduct artificial thought experiments that result in moral judgements. Instead, she works together with the participants involved in an actual situation in which informed consent seems to be needed.

In any global context, these participants will very likely speak different languages, and language barriers are quite difficult to overcome. There is no easy solution to this problem: it takes a willingness on all sides to learn as much as possible of the others' languages, not only for purposes of facilitating communication, but also because initiation into a language constitutes initiation into a culture. To acquire a language is to acquire patterns of thought, a sense of what strikes its speakers as funny and what is taken for granted. A common language such as English is very helpful, but native English speakers in particular must work hard to learn the language of their interlocutors, for that is the best way of getting to know their culture.

Once the bioethicist has acquired at least a rudimentary understanding of the language of those with whom she collaborates, she encourages them to start with reflective analysis: the participants generate a description of the various assignments of responsibility that operate in their situation, along with the moral understandings that undergird them. As the bioethicist and participants critically reflect on these understandings—especially when they track the identified responsibilities—the bioethicist might ask the participants to be alert to unjust imbalances of power, manipulation, or even force. In normative reflection, the group proceeds by comparison, weighing the merits of different ways of proceeding they know about or can imagine. They draw on their shared moral understandings as they try to decide which course of action would be better than others.

MORAL REFLECTION FOR A GLOBALISED BIOETHICS

Globalising a naturalised, particularistic bioethics underscores the importance of dealing with two ethical questions (see table 1):

1. The question of moral responsibility: to whom am I (are we) morally responsible? Because a naturalised global bioethics views morality as consisting of relations of recognition and responsibility, more attention must be paid to such issues such as:

- (a) global distributive justice (allocation of scarce medical resources)
- (b) intergenerational justice (conservation, sustainability)
- (c) intragenerational responsibility (biobanks)
- (d) intertwinement of responsibilities (research ethics).

Mapping responsibilities in global settings involves paying attention to different social positions (including our own as ethicists), gathering all kinds of information (including information about how responsibilities are assigned and who is accountable to whom), thinking carefully about who is vulnerable when the assignments are made in that way, and trying to find out what authority the moral understandings that operate in that context have. In principle, every moral issue should be addressed from this relational perspective.

Table 1 Responsibility and justification

Reflective analysis (descriptive)	Tracking responsibilities: who is responsible for what? Who is accountable to whom? What moral understandings are at play in the situation?
Critical reflection (normative)	Does everyone share the operative moral understandings? Are they justifiable in their own moral terms? Do they serve only the interests of the powerful?
Normative reflection (normative)	Where do the shared understandings get their legitimacy? Do we know, or can we imagine, more morally sound ways to proceed?

2. The question of moral justification: to whom am I (are we) morally accountable? In a way this question is intertwined with the first one. In recognising the other as someone to whom I bear responsibility, I recognise that person as someone to whom I am accountable. Whether the original assignment of responsibility is morally justified can only be decided by using the resources within existing practices of responsibility, but because these assignments are often epistemically rigged to appear innocent when in fact they are not, justification seeks transparency in moral life.²² Sabina Lovibond²⁴ invokes this ideal in her conception of 'a community whose members understood their own form of life and yet were not embarrassed by it'.

CONCLUSION

At first glance, it might look as if we are espousing a kind of ethical relativism. Because a particularistic, naturalised bioethics understands morality as an interpersonal practice arising out of what goes on between or among people, it might be thought that morality is merely a social construction, with no authority apart from whatever people happen to give it. In our view, though, there is nothing 'mere' about a social construction. Social constructions are real, and they have a real impact on people's wellbeing. Indeed, people themselves are essentially social constructions, initially shaped through their interactions with their parents and the others in their community who give them their second natures, and then held in personhood through the patterns of recognition and response that constitute their lives together. To ask why we should submit to the moral norms on offer in our particular social world is to ask why we should let our lives be regulated by the very practices and institutions without which we would not have any selves at all.

To be sure, we need not submit to all the moral norms operative in our society. Any system of morality (as opposed to raw power) contains resources for criticising and contesting norms that are cruel, dismissive of certain kinds of people, or exploitative. We do not, then, subscribe to the idea that whatever a given society says is right and wrong is in fact what is right and wrong in that society, but we are sceptical of the existence of transcendental moral standards against which socially shared moral understandings could be measured.

We do not deny that some moral principles ('Do not torture the innocent', 'Murder is wrong') have universal scope. We merely deny that socially and temporally transcendent moral standards could possibly help us determine what such principles might mean in a given situation. If these standards truly stand outside society, they cannot engage what goes on inside it, nor would we have epistemic access to them. Our plight is something more like that of Otto Neurath's famous mariners: moral knowledge is like a raft at sea that we continually rebuild while staying afloat on it.²⁵

A final point. It might be thought that, in rejecting a certain kind of normative theory, we are rejecting moral theorising tout court. We are not. The resources we offer—reconceptualising morality as an interpersonal, collaborative practice; moral particularism; reflective analysis; critical and normative reflection—are fully theoretical. Because they part company with the moral theories that have dominated western culture for the past several hundred years, they have somewhat misleadingly been dubbed antitheory. We hope they are not that. Theory is vital to any sound practice, perhaps especially the practice of morality. Our aim in this paper has been, rather, to replace what we see as inapt, ill-fitting theory with something that better suits a globalised bioethics.

Competing interests None.

Provenance and peer review Not commissioned; externally peer reviewed.

REFERENCES

1. **Holm S**, Williams-Jones B. Global bioethics—myth or reality? *BMC Med Ethics* 2006;**7**:10.
2. **Glasner P**, Rothman H. New genetics, new ethics? globalisation and its discontents. *Health Risk Soc* 2001;**3**:245–59.
3. **Ruger JP**. Ethics and governance of global health inequalities. *J Epidemiol Community Health* 2006;**60**:998–1002.
4. **Hopewell S**, Loudon K, Clarke MJ, *et al*. Publication bias in clinical trials due to statistical significance or direction of trial results. *Cochrane Database Syst Rev* 2009; (1):MR000006. doi:10.1002/14651858.MR000006.pub3.
5. **Beauchamp TL**, Childress JF. *Principles of Bioomedical Ethics*. 5th edn. Oxford: Oxford University Press, 2001.
6. **De Vries R**, Low LK, Bogdan-Lovis E. Choosing surgical birth: desire and the nature of bioethical advice. In: Lindemann H, Walker MU, Verkerk MA, eds. *Naturalized Bioethics: Toward Responsible Knowing and Practice*. New York, NY: Cambridge University Press, 2008.
7. **Daniels N**. *Just Health*. Cambridge: Cambridge University Press, 2008.
8. **Abdallah S**, Daar S, Singer PA. Global health ethics: the rationale for mutual caring. *Int Aff* 2003;**79**:107–38.
9. **Sidgwick H**. *The Methods of Ethics*. 7th edn. Indianapolis, IN: Hackett, 1981.
10. **Pogge TW**. Human rights and global health: a research program. *Metaphilosophy* 2005;**36**:182–209.
11. **Hellsten SK**. Global bioethics: utopia or reality? *Dev World Bioeth* 2008;**8**:70–81.
12. **Aulisio M**. Bioethics in a global village. *Am J Bioeth* 2006;**6**:1–4.
13. **Jaggar AM**. Globalizing feminist ethics. *Hypatia* 1998;**13**:7–31.
14. **Baylis F**, Kenny NP, Sherwin S. A relational account of public health ethics. *Public Health Ethics* 2008;**1**:196–209.
15. **Widdows H**, Dickenson D, Hellsten S. Global bioethics. *New Rev Bioeth* 2003;**1**:101–16.
16. **Young IM**. *Justice and the Politics of Difference*. Princeton, NJ: Princeton University Press, 1990.
17. **Miller EA**. The technical and interpersonal aspects of telemedicine: effects on doctor–patient communication. *J Telemed Telecare* 2003;**9**:1–7.
18. **Stocker M**. The schizophrenia of modern ethical theories. *J Philos* 1976;**73**:453–66.
19. **Calhoun C**. Justice, care, gender bias. *J Philos* 1988;**9**:451–63.
20. **Taylor Ch**. *Sources of the self. the making of modern identity*. Cambridge, UK: Cambridge University Press, 1989.
21. **Baylis F**, Downey J. Child abuse and neglect: cross-cultural considerations. In: Lindemann Nelson H, ed. *Feminism and families*. London: Routledge 1996:173–87.
22. **Walker MU**. *Moral Understandings. A Feminist Study in Ethics*. 2nd edn. New York, NY: Oxford University Press, 2007.
23. **Lindemann H**, Verkerk MA, Walker MU, eds. *Naturalized bioethics: toward responsible knowing and practice*. Cambridge: Cambridge University Press, 2008.
24. **Lovibond S**. *Realism and Imagination in Ethics*. Minneapolis, MN: University of Minnesota Press, 1983.
25. **Neurath O**. Philosophical Papers 1913–194. In: Cohen RS, Neurath M, eds. Dordrecht: Reidel.